Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $248.00 for date of service, 08/16/01.

   b. The request was received on 05/09/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 01/17/03. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 01/21/03. The response from the insurance carrier was received in the Division on 01/28/03. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Supplemental Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/08/02

   "(Carrier) denied or reduced payment based on exception codes **F Fee Guideline MAR reduction** [sic] Used when the IC is reducing payment from the billed amount in accordance with the appropriate TWCC fee guidelines MAR, including when the IC is paying for a generic pharmaceutical at the brand name price because the brand name price is lower. NOT used for reductions based on lack of documentation or for charges for which TWCC has not established an MAR. When (Carrier) denied or reduced the payment based on this exception code, (Carrier) did not reimburse (Requestor) at the correct MAR. **Please see the TWCC Fee Guidelines pages 19, 182 for the correct amount**, or please reference pages 38 and 39 in our packet…."

2. Respondent: Letter undated

   "THE PROVIDER HAS NOTED THAT ALL OF THE ISSUES, OTHER THAN 8/16/01, HAVE BEEN RESOLVED. IN REVIEW OF THE 8/16/01 SERVICE, THE PROVIDER BILLED 64999, $248.00. ACCORDING OT [sic] THE DOCUMENTATION, THE PROVIDER PERFORMED A '**PARAVERTEBRAL REGIONAL NERVE BLOCK**'. THE PROVIDER, BASED ON HIS OWN DOCUMENTATION, IS USING, INAPPROPRIATELY, AN UNLISTED CODE. IN THE TWCC MFG, PAGE 179, THE CODE **64441** DESCRIBES THE PROCEDURE PERFORMED ON THIS DATE. THE PROVIDER HAS BILLED A CHARGE OF $248.00 FOR THIS SERVICE. THE CODE 64441 ALLOWS, PER MFG, MUCH LESS. THE CARRIER FEELS THE DENIAL OF THIS CHARGE WAS CORRECT, AS THE PROVIDER HAS BILLED INAPPROPRIATELY FOR THE SERVCIES [sic] RENDERED."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/16/01. The Requestor has withdrawn all other dates listed on the original Table of Disputed Services received 05/09/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $248.00 for services rendered on the date above.

4. Per the Requestor's initial Table of Disputed Services, the Carrier paid the Requestor $0.00 for services rendered on the date above and denied reimbursement as "F-SUBMITTED DOCUMENTATION INDICATES THAT THE LISTED SERVICE DOES NOT MEET THE CRITERIA IDENTIFIED IN THE FEE GUIDELINE GROUND RULES AND/OR CODE DESCRIPTION FOR REIMBURSEMENT".

5. Per the Requestor's updated Table of Disputed Services received on 02/27/03, the amount in dispute is $248.00 for services rendered on the date of service in dispute above.

6. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
08/16/01	64999	$248.00	$0.00	F	DOP	MFG General Instructions (III); TWCC Rule 133.304 (c); 133.307 (g) (3) (D); CPT Descriptor	The Requestor has billed CPT code 64999, which is a DOP (no MAR) per the MFG. The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. **CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate** (bolded for emphasis)." The Carrier's denial of "F" is inappropriate for a DOP CPT code. Additionally, TWCC Rule 133.304 states "The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The Carrier's EOB does not address or support their denial for CPT Code billed. Therefore, the Carrier has not supported their denial in accordance with TWCC Rule 133.304 (c). Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The provider has supplied EOBs from other carriers with the unlisted DOP code 64999. One of these EOBs is for another provider. The other two have 2 different money amounts and there is no medical attached to indicate these unlisted procedures were the same as for this claim. In this case, the provider has not submitted sufficient documentation to support this; therefore, no reimbursement is recommended.
Totals		$248.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 3rd day of March 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt